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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LARRY VEGA MACAVINTA** **24333 E. Thunder Trail** **Diamond Bar, CA 91765** **Registered Nurse License No. 583408** Respondent.	Case No. 2013-969 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 13, 2001, the Board of Registered Nursing issued Registered Nurse License Number 583408 to Larry Vega Macavinta (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2015, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISION

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

REGULATORY PROVISIONS

7. Title 16, California Code of Regulations, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. Title 16, California Code of Regulations, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5, states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FACTUAL ALLEGATIONS

11. In December of 2009, Respondent was working as a Registered Nurse at Corona Regional Medical Center (Corona) in Corona, California. He had worked there for approximately 9 years.

12. On December 2, 2009, at approximately 2010, RV (a 43 year old man), arrived at Corona by ambulance with a high blood alcohol level, altered level of consciousness, alcohol intoxication, and a history of pancreatic cancer.

13. RV's alcohol level of .50 or 505 mg/dl was extremely high and quantified as possibly fatal.

14. Respondent was RV's primary nurse.

15. RV was uncooperative and combative, cussing and spitting at the staff and thrashing on the gurney. Nursing staff requested chemical sedation to control him.

16. After evaluating RV, he was placed on a monitor, a mask was placed on his face, he was given a Foley catheter, IV fluids, and he was placed in restraints.

17. At 2020, RV was administered intravenous Narcan. RV's neurological status fluctuated, but improved to the point where he was speaking with slurred speech at 2155.

18. At 0140, RV was given Geodon (an atypical antipsychotic) by another nurse.

19. Hospital protocol was for all restrained and all sedated patients to be closely monitored and documented. Other than Respondent who was monitoring RV, along with several other patients, no one was assigned to watch RV.

20. RV continued to thrash about, removing his IV and monitors. The IV was not replaced and for periods of time his monitors were not attached. Without doctor's orders, an additional chest restraint was applied.

21. The charge nurse instructed Respondent to put the patient on a monitor and that his oxygen was off, but Respondent did not follow those orders. There were numerous inconsistent or inadequacies in the charting of RV's vitals.

22. At 0230, a nurse note reflected that RV was responsive and pulse oximetry was 90%.

23. At 0300, RV's pulse oximetry was 81% and the monitor was off. Respondent was informed by the charge nurse that the patient was not being monitored and that his saturation was low. Respondent did not call the doctor. The patient deteriorated and went into cardiac arrest.

24. At 0330, RV was not breathing. No IV or monitor was attached to him. He was still in restraints.

25. The doctor was called at 0355 and Advanced Cardiac Life Support was started, but the patient died on December 3, 2009 at 0412 hours.

26. Contrary to hospital protocol, Respondent did not chart any of his care of the patient until after the patient died. RV had spent 8 hours in the ER.

27. On December 7, 2009, the Board received an anonymous complaint, which led to the investigation into this matter.

28. On December 18, 2009 Respondent was terminated from his position for unacceptable job performance for failing to provide appropriate patient monitoring to RV.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent has subjected his registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that he was grossly negligent, as defined by Title 16, California Code of Regulations, section 1442, in that during the period from December 2, 2009 to December 3, 2009, while employed at Corona (as detailed in paragraphs 11 to 28, above), Respondent's conduct demonstrated an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse's actions. The lack of appropriate monitoring of RV contributed to his demise. Regardless of the actual cause of his death, the lack of adequate monitoring was not within acceptable standards. Throughout the course of hospitalization, there is no documentation of a communication to the physician of a deterioration of the patient condition (desaturation documented in the electronic record) and that deterioration was not recognized by Respondent as he was not monitoring RV per hospital procedure and patient situation. The omission of significant vital signs that were not acted upon demonstrates a lack of observing the vital signs

and taking actions to prevent harm, and was neglectful. The additional restraint was not per hospital protocol, was not ordered by a physician, and would potentially warrant additional interventions, which were not taken.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

30. Respondent has subjected his registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that he was incompetent, as defined by Title 16, California Code of Regulations, section 1443, in that during the period from December 2, 2009 to December 3, 2009, while employed at Corona (as detailed in paragraphs 11 to 29, above), Respondent repeatedly demonstrated he did not possess the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse in that he failed to properly monitor and insure RV's safety when he was extremely intoxicated, under numerous restraints, under sedation, disconnected from an IV, often not electronically monitored, and not properly monitored by Respondent. Respondent should have understood alcohol intoxication and sedation required monitoring to prevent patient harm. If Respondent was unable to adequately monitor the patient, he should have utilized his chain of command to advocate for his patient's safety.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 583408, issued to Larry Vega Macavinta;

2. Ordering Larry Vega Macavinta to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: APRIL 26, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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